Appalachian Therapeutic Riding Center
Participant's Application and Health History

GENERAL INFORMATION

Participant _____

Disability _____ Date of Onset _____

DOB _____ Age _____ Height _____ Weight _____ M F

Address _____
Street / PO Box *City* *State* *Zip*

Phone _____ Alternative Phone # _____

Employer / School _____Phone # _____

Address _____
Street / PO Box *City* *State* *Zip*

Parent / Legal Guardian _____Phone# _____

Address (if different from above) _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognition			
Allergies			

Tetanus Shot Yes _____ No _____ Date _____

Warning: Under North Carolina Law, an equine activity sponsor or equine professional is not liable for an injury to or the death of a participant in equine activities resulting exclusively from the inherent risks of equine activities. Chapter 99E of the North Carolina Statues.

What medications is participant currently taking, including over-the –counter medication? _____

Describe the participant's abilities / difficulties in the following areas (include assistance required or equipment needed.)

FUNCTION *(ie Mobility skills such as transfers, walking, wheelchair use, driving / bus riding)*

SOCIAL *(ie work/school including grade completed, leisure interests, companion animals, fears/ concerns, etc.)*

GOALS *(ie Reasons for participation? What want to accomplish?)*

No one can be accepted for participation in equestrian activities until all forms have been completed by the parent or legal guardian. Equestrian activities will be under supervision and although every effort will be made to avoid any accident, NO LIABILITY can be accepted by any of the organizations or individuals concerned including Appalachian Therapeutic Riding Center and its representatives.

I would like _____ to participate in equestrian activities and I have discussed this with the participant's physician. I understand that NO LIABILITY can be accepted by any of the organizations concerned with this participation, including Appalachian Therapeutic Riding Center and its representatives.

Signature _____ Date _____
Participant, parent or legal guardian

Witness _____ Date _____